| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE : COMPL | |
|--|---------------------|---------------------------------------|--------|------------|--|----------------------|------------|
| AND PLAN | OF CORRECTION | 155567 | | LDING | 00 | 02/22/ | |
| | | 100007 | B. WIN | | ADDRESS CITY STATE ZID CODE | OZIZZI | 2010 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALTI | H AND REHABILITATION CENTE | R | | VAYNE, IN 46825 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| F0000 | REGULATORY OR | LSC IDENTIFYING INFORMATION) | 1 | TAG | DEFICIENCE!) | | DATE |
| 1 0000 | | | | | | | |
| | This visit was f | or a Recertification and | F00 | 00 | | | |
| | State Licensure | e Survey. | | | | | |
| | | , | | | | | |
| | Survey dates: I | February 18, 19, 20, | | | | | |
| | 21, 22, 2013 | | | | | | |
| | | | | | | | |
| | Facility number | | | | | | |
| | Provider numb | | | | | | |
| | AIM number: 1 | 00289700 | | | | | |
| | | | | | | | |
| | Survey team: | T0 | | | | | |
| | Tim Long, RN, | IC | | | | | |
| | Rick Blain, RN | NI. | | | | | |
| | Carol Miller, RN | | | | | | |
| | Diane Nilson, F | KIN | | | | | |
| | Census bed typ | oe: | | | | | |
| | SNF: 2 | | | | | | |
| | SNF/NF: 69 | | | | | | |
| | Total: 71 | | | | | | |
| | | | | | | | |
| | Census Payor | type: | | | | | |
| | Medicare: 10 | | | | | | |
| | Medicaid: 46 | | | | | | |
| | Other: 15 | | | | | | |
| | Total: 71 | | | | | | |
| | These deficien | cies reflect state | | | | | |
| | | n accordance with 410 | | | | | |
| | IAC 16.2. | 1 accordance with T10 | | | | | |
| | | | | | | | |
| | Quality review | completed on February | | | | | |
| | 26, 2013 by Ra | · · · · · · · · · · · · · · · · · · · | | | | | |
| | | - - | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155567 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPI 02/22 | LETED | | |
|--------------------------|---------------------|---|---|---|-------------|----------------------------|--|--|
| | PROVIDER OR SUPPLIE | R TH AND REHABILITATION CENTE | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|---|----------------------|--|------------|--------|--|--------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A DIJII DI | INIC | 00 | COMPL | ETED |
| | | 155567 | A. BUILDI | ING | | 02/22/ | 2013 |
| | | | B. WING | | | _ | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALTI | H AND REHABILITATION CENTER | ۱ ۲ | FORT V | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PR | REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE |
| F0157 | 483.10(b)(11) | , | | | | | |
| SS=D | NOTIFY OF CHA | NGES | | | | | |
| 00 B | (INJURY/DECLIN | | | | | | |
| | , | mediately inform the | | | | | |
| | | with the resident's | | | | | |
| | | known, notify the resident's | | | | | |
| | | ve or an interested family | | | | | |
| | | ere is an accident involving | | | | | |
| | | h results in injury and has | | | | | |
| | the potential for re | equiring physician | | | | | |
| | | gnificant change in the | | | | | |
| | | al, mental, or psychosocial | | | | | |
| | • | erioration in health, mental, | | | | | |
| | or psychosocial s | | | | | | |
| | threatening condi | | | | | | |
| | • | need to alter treatment | | | | | |
| | | a need to discontinue an | | | | | |
| | - | reatment due to adverse | | | | | |
| | • | r to commence a new form a decision to transfer or | | | | | |
| | | ident from the facility as | | | | | |
| | specified in §483. | | | | | | |
| | specified in 9400. | . 12(a). | | | | | |
| | The facility must a | also promptly notify the | | | | | |
| | | nown, the resident's legal | | | | | |
| | | interested family member | | | | | |
| | when there is a cl | | | | | | |
| | | ment as specified in | | | | | |
| | | a change in resident rights | | | | | |
| | | State law or regulations as | | | | | |
| | specified in parag | graph (b)(1) of this section. | | | | | |
| | | | | | | | |
| | | record and periodically | | | | | |
| | | ss and phone number of | | | | | |
| | | al representative or | | | | | |
| | interested family | member. | | | | | |
| | | | F0157 | 7 | It is the policy of this facility to | | 03/22/2013 |
| | Based on recor | rd review and | | | notify the M.D. of any written | | |
| | interview, the fa | acility failed to notify | | | recommendations by the Registered Dietican. I. There was | | |
| | | | | | | | |
| the physician of a recommendation the Registered Dietitian to start a | | | | | no negative outcome for the | | |
| | e Negistereu | | <u> </u> | | resident. The resident desired | το | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet Page 3 of 29

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURV | /EY | |
|--|-------------------------|------------------------------|-----------------------|-------------|--|------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | |) | |
| | | 155567 | | | | 02/22/2013 | 3 |
| | | | B. WIN | | ADDRESS OFTW STATE ZID CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEI | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | ILLAND DELIADILITATION CENTE | П | | EDICAL PARK DR | | |
| UNIVER | SIIY PARK HEALI | H AND REHABILITATION CENTE | K | FORTV | WAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re COI | MPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | nutritional sup | olement to address | | | lose wt.II. No other residents | | |
| | weight loss for | 1 of 35 sampled | | | were affectes, or identified.Ad | | |
| | residents revie | wed for physician | | | were done on all recent quarte | • | |
| | notification (Re | | | | resident assessments to ensu that any dietary | e | |
| | (*** | | | | recommendations were | | |
| | Findings include | ۱۵۰ | | | completed.See attachments # | 3 | |
| | | | | | a,b,c)III. The Registered Dietic | | |
| | The record for | Resident #23 was | | | will implement the approved | | |
| | | | | | Covenant Care recommendati | | |
| | | /20/12 at 10:00 A.M. | | | forms, (see attachment # 1) to | | |
| | | luded, but were not | | | ensure that the recommendati | | |
| | limited to, diab | etes mellitus. | | | are reviewed timely. A review re-education of the procedure | | |
| | | | | | recommendation, completed v | | |
| | The facility Ass | sistant Director of | | | RD. and Dietary Manager.(Se | | |
| | Nursing (ADOI | N) was interviewed on | | | attachment II)A. The RD will e | | |
| | 2/18/2013 at 2 | :00 P.M. During the | | | with the DON or Designee and | | |
| | | ADON indicated | | | review her recommendations v | vith | |
| | | was not receiving any | | | a verbal and written | | |
| | | olements. The ADON | | | recommendation report.B. A a | | |
| | | ed if a resident was | | | tool will be implemented to tra all RD recommendations week | | |
| | | ritional supplement, the | | | (see attachment # 2+3) DON | • | |
| | _ | • • | | | Designee will monitor and aud | | |
| | | of the supplement | | | the RD's list weekly to ensure | | |
| | | ated on the Medication | | | compliance. IV. The weekly at | ıdit | |
| | Administration | Record (MAR). | | | tools will be brought to the | | |
| | | | | | monthly QMP meetings for | | |
| | | veights for Resident | | | compliance review by the committee, for 6 mos.V. Date | | |
| | #23, provided | by the facility Medical | | | completed 3/22/2013 | | |
| | Records Direc | tor on 2/20/2013 at | | | Completed 5/22/2015 | | |
| | 3:10 P.M., indi | cated the resident had | | | | | |
| | weighed 143.2 | pounds on 11/21/2012 | | | | | |
| | _ | ed 131.00 pounds on | | | | | |
| | _ | dicating an 8.5% | | | | | |
| | weight loss in 77 days. | | | | | | |
| | weight loss in 77 days. | | | | | | |
| | A note by the | Pagistared Distition | | | | | |
| | | Registered Dietitian | | | | | |
| | (RD), dated 2/(| 6/13, indicated "RD | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|--|---------------------|--------------------------------|---------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | LETED |
| | | 155567 | B. WIN | | | 02/22 | /2013 |
| | | <u> </u> | . ,, 11 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIE | R | | | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENT | ER | | VAYNE, IN 46825 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | | ent 2/4/13 wt (weight): | | | | | |
| | | represents a 2% wt | | | | | |
| | 1 | s & an 8% wt loss in 90 | | | | | |
| | | vt loss at 180 days" | | | | | |
| | The note also | indicated "Will | | | | | |
| | recommend he | ealth shake (nutritional | | | | | |
| | supplement) o | nce daily to (increase) | | | | | |
| | daily Kcal (kilo | calorie)/pro (protein) | | | | | |
| | intakes." | | | | | | |
| | | | | | | | |
| | The MAR for F | ebruary 2013 for | | | | | |
| | | did not indicate the | | | | | |
| | | egun receiving health | | | | | |
| | shakes after 2 | | | | | | |
| | recommended | | | | | | |
| | recommended | by the RD. | | | | | |
| | A review of cu | rrent physician orders | | | | | |
| | | 23 indicated an order | | | | | |
| | | | | | | | |
| | 1 | nake" had been entered | | | | | |
| | | 's computer system on | | | | | |
| | · | he order was still | | | | | |
| | indicated as "p | ending" as of | | | | | |
| | 2/21/2013. | | | | | | |
| | | | | | | | |
| | 1 | ON was interviewed on | | | | | |
| | | :50 A.M. The ADON | | | | | |
| | | order for the health | | | | | |
| | shake was still | indicated as "pending" | | | | | |
| | in the compute | er because the | | | | | |
| | physician had | not yet signed the | | | | | |
| | order and the | order had not yet been | | | | | |
| | | The ADON indicated | | | | | |
| | | parently entered the | | | | | |
| | • | on to start the health | | | | | |
| | | sident #23 into the | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet Page 5 of 29

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567 | A. BUI | LDING | NSTRUCTION 00 | (X3) DATE COMPL 02/22/ | ETED |
|-----------|----------------------------------|--|--------|--------|---|------------------------------|------------|
| | | 100007 | B. WIN | | DDDEGG CUTY CTATE TID CODE | OZIZZI | 2010 |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | | DDRESS, CITY, STATE, ZIP CODE | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENTE | ER | | EDICAL PARK DR VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | - | /6/2013 and the | | | | | |
| | | on had appeared in the | | | | | |
| | | em as a pending order. | | | | | |
| | | icated the RD had not | | | | | |
| | | ursing staff of the | | | | | |
| | recommendation | | | | | | |
| | | ursing staff would have | | | | | |
| | | sician if they had been | | | | | |
| | | commendation and | | | | | |
| | | re documented the | | | | | |
| | | he Nursing Notes. The | | | | | |
| | | d the physician would | | | | | |
| | have then sign | | | | | | |
| | _ | nd the order would | | | | | |
| | | n indicated as having | | | | | |
| | _ | he ADON indicated the | | | | | |
| | | ve then been entered | | | | | |
| | | nt's MAR and the | | | | | |
| | | have started receiving kes. The ADON was | | | | | |
| | | | | | | | |
| | • | de any documentation indicate the physician | | | | | |
| | had been notifi | • • | | | | | |
| | | on, or had approved of | | | | | |
| | | order. The ADON | | | | | |
| | _ | ealth shakes for | | | | | |
| | | vere not on the MAR | | | | | |
| | | 013 and the shakes | | | | | |
| | had not yet be | | | | | | |
| | Had Hot yet bet | on starteu. | | | | | |
| | The facility Dire | ector of Nursing (DON) | | | | | |
| | • | d on 2/21/2013 at | | | | | |
| | | iring the interview, the | | | | | |
| | | the physician was not | | | | | |
| | | ecommendation for | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CONST A. BUILDING | TRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|------------------------------------|---|-----------------------------|
| | 155567 | B. WING | | 02/22/2013 |
| | PROVIDER OR SUPPLIER SITY PARK HEALTH AND REHABILITATION CENTE | 1400 MED | DRESS, CITY, STATE, ZIP CODE DICAL PARK DR YNE, IN 46825 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| | the health shake until 2/21/12 and he had denied the order for the health shake and instead, had ordered Glucerna (a nutritional supplement) for the resident. 3.1-5(a)(3) | | | |
| | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155567 155567 22/22/2013 22/22/201 | STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|--|-----------|--|--|---------|------------|---|------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER IN SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES TAG REGITATORY OR ISE ININITIVING INFORMATION) FORT WAYNE, IN 46825 SS=D MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident 1 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on a resident grain and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIJII | DING | 00 | COMPL | ETED |
| It is the policy of this facility to review all registered Diettian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/20/13 at 2:00 P.M. During the interview, the ADON) indicated Resident \$23 was not receiving any nutritional supplements. The ADON | | | 155567 | | | | 02/22/ | 2013 |
| UNIVERSITY PARK HEALTH AND REHABILITATION CENTER IN 1400 MEDICAL PARK DR FORT WAYNE, IN 46825 ID PRETEX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO325 SS=D ANINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIVERSITY PARK HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICENCY MUST BE REFICEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO325 SS=D AMINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on a record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | NAME OF P | ROVIDER OR SUPPLIER | | | 1400 M | EDICAL PARK DR | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE | UNIVERS | SITY PARK HEALTI | H AND REHABILITATION CENTE | ₹ | | | | |
| F0325 SS=D ANA/OIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| F0325 SS=D MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a residents comprehensive assessment, the facility must ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic cliet when there is a nutritional problem. Based on record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23). Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| MAINTÁIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23). Findings include: Findings include: The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus. The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON | | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| further indicated if a resident was Attachment # 2).B. An audit tool | F0325 | 483.25(i) MAINTAIN NUTR UNAVOIDABLE Based on a reside assessment, the resident - (1) Maintains acconutritional status, protein levels, unled condition demons possible; and (2) Receives a the anutritional problem and proble | ent's comprehensive facility must ensure that a eptable parameters of such as body weight and less the resident's clinical strates that this is not erapeutic diet when there is em. or d review and acility failed to commendation by the titian to start a plement to address 1 of 3 residents utrition in a sample of 5 met the criteria for lent #23). The Resident #23 was 20/12 at 10:00 A.M. uded, but were not etes mellitus. The sistant Director of Sistant Director o | F03 | | It is the poilcy of this facility to review all Registered Dietican recommendations, with the attending M.D.for implementation!. There was not negative outcome for the resident, the resident desired to lose wt.II. No other residents were affected or identified. Aud were done on all recent quarter resident assessments to ensure that dietary recommendations were completed. (See attachments # 3 a,b,c) III. The Registered Dietician will implement the approved Covenant Care recommendatifrom, (see attachment # 1) to ensure that recommendations reviewed timely. A review and re-education of the procedure recommendation completed w RD and Dietary Manager. (See attachment II)A. The RD will exwith the DON or Designee and review her recommendations was verbal and written recommendation report. (see | odits on are of ith exit ith | |

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Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | JLTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY | |
|--|--------------------|--------------------------------|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DIII | DDIG | 00 | COMPLI | ETED |
| | | 155567 | A. BUII | | | 02/22/ | 2013 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIE | R | | | | | |
| LINII\/EDG | SITY DADK HEALT | U AND DEHABILITATION CENTE | D | | EDICAL PARK DR | | |
| UNIVERS | SIIT PARK HEALI | H AND REHABILITATION CENTE | ĸ | FURIV | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | receiving a nut | tritional supplement, the | | | will be implemented to track a | | |
| | administration | of the supplement | | | RD recommendations | ٠, ا | |
| | would be indic | ated on the Medication | | | weekly. (see attachment # 2& DON or Designee will monitor | · . | |
| | Administration | Record (MAR). | | | and audit the RD's list weekly | | |
| | | , | | | ensure compliance.IV. The au | | |
| | A print out of v | veights for Resident | | | tools will be brought to the | - | |
| | • | by the facility Medical | | | monthly QMP meetings for | | |
| | | tor on 2/20/2013 at | | | compliance review by the | | |
| | | | | | committee for 6 mos.V. Date | | |
| | | cated the resident had | | | completed: 3/22/2013 | | |
| | • | 2 pounds on 11/21/2012 | | | | | |
| | _ | ed 131.00 pounds on | | | | | |
| | | dicating an 8.5% | | | | | |
| | weight loss in | 77 days. | | | | | |
| | | | | | | | |
| | A note by the I | Registered Dietitian | | | | | |
| | (RD), dated 2/ | 6/13, indicated "RD | | | | | |
| | ` ' | ent 2/4/13 wt (weight): | | | | | |
| | | represents a 2% wt | | | | | |
| | | s & an 8% wt loss in 90 | | | | | |
| | _ | | | | | | |
| | | rt loss at 180 days" | | | | | |
| | The note also | | | | | | |
| | | ealth shake (nutritional | | | | | |
| | | nce daily to (increase) | | | | | |
| | | calorie)/pro (protein) | | | | | |
| | intakes." | | | | | | |
| | | | | | | | |
| | The MAR for F | ebruary 2013 for | | | | | |
| | | did not indicate the | | | | | |
| | | egun receiving health | | | | | |
| | shakes after 2 | • | | | | | |
| | recommended | | | | | | |
| | Tecommended | by the ND. | | | | | |
| | A rovious of acc | rrant physician ardara | | | | | |
| | | rrent physician orders | | | | | |
| | | 23 indicated an order | | | | | |
| | for Healthy Sh | ake had been entered | | | | | |

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PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUI | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | survey eted '2013 | | |
|---|---|--|--|---------------------|--|-------------------------|----------------------------|--|
| | ROVIDER OR SUPPLIER | L : H AND REHABILITATION CENTE | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE | |
| | 2/6/2013, but the indicated as "p 2/21/2013. | · | | | | | | |
| | 2/21/2013 at 9: indicated the o shake was still | ON was interviewed on 50 A.M. The ADON rder for the health indicated as "pending" | | | | | | |
| | order and the complemented. the RD had ap | r because the not yet signed the order had not yet been The ADON indicated parently entered the on to start the health | | | | | | |
| | shakes for Res computer on 2/ recommendation computer system | sident #23 into the /6/2013 and the on had appeared in the em as a pending order. | | | | | | |
| | informed the no recommendation indicated the n | icated the RD had not ursing staff of the on. The ADON ursing staff would have sician if they had been | | | | | | |
| | they would have notification in the ADON indicate | ecommendation and we documented the he Nursing Notes. The and the physician would | | | | | | |
| | and the order vindicated as had ADON indicated then been enter | e order electronically vould have then been aving been signed. The d the order would have ered onto the resident's | | | | | | |
| | | esident would have ng the health shakes. | | | | | | |

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Event ID: 0WU111

Facility ID: 000459

If continuation sheet Page 10 of 29

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------------------------|------------------------------|--------|-------------|---|------------------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 155567 | B. WIN | | | 02/22/2013 | |
| MANGOES | NOTABLE OF GLASS ASS | 1 | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1400 MI | EDICAL PARK DR | | |
| | | H AND REHABILITATION CENTI | ĒR | | VAYNE, IN 46825 | <u>,</u> | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5 | • |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | DATI | |
| | | s unable to provide any | | | | | |
| | | in the record to | | | | | |
| | · · · · · · · · · · · · · · · · · · · | ysician had been | | | | | |
| | | ecommendation, or | | | | | |
| | | of, and signed the | | | | | |
| | | ON indicated the | | | | | |
| | | for Resident #23 were | | | | | |
| | | R for February 2013 | | | | | |
| | and the shakes | s had not yet been | | | | | |
| | started. | | | | | | |
| | | | | | | | |
| | The facility Dire | ector of Nursing (DON) | | | | | |
| | was interviewe | d on 2/21/2013 at | | | | | |
| | 10:15 A.M. Du | ring the interview, the | | | | | |
| | DON indicated | she had spoken with | | | | | |
| | the RD by telep | phone and the RD had | | | | | |
| | indicated she tl | hought when she | | | | | |
| | entered a reco | mmendation into the | | | | | |
| | facility's compu | iter system, the | | | | | |
| | • | on would automatically | | | | | |
| | | o the resident's MAR. | | | | | |
| | | ated the RD had not | | | | | |
| | informed nursir | | | | | | |
| | | on for the health shake. | | | | | |
| | | ated the physician was | | | | | |
| | | he recommendation | | | | | |
| | | hake until 2/21/12 and | | | | | |
| | | the order for the health | | | | | |
| | | eadhad ordered | | | | | |
| | | tritional supplement) | | | | | |
| | for the resident | • • • • • • | | | | | |
| | | | | | | | |
| | 3.1-46(a)(1) | | | | | | |
| | 0.1 =10(α)(1) | | | | | | |
| | | | | | | | |
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PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155567 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | LETED 2/2013 | | | |
|--------------------------|--|---|---|---|---------|----------------------------|--|--|--|
| | PROVIDER OR SUPPLIER SITY PARK HEALTI | H AND REHABILITATION CENTE | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

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Event ID: 0WU111

Facility ID: 000459

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| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MI | JLTIPLE CC | ONSTRUCTION | (X3) DATE S | SURVEY |
|-----------|---|-------------------------------|---------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | DDIG | 00 | COMPL | ETED |
| | | 155567 | A. BUII | | | 02/22/ | 2013 |
| | | | B. WIN | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENTE | R | FORT | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0356 | 483.30(e) | | | | | | |
| SS=C | POSTED NURSE | STAFFING | | | | | |
| | INFORMATION | | | | | | |
| | The facility must | post the following | | | | | |
| | information on a daily basis: | | | | | | |
| | o Facility name. o The current date. | | | | | | |
| | | | | | | | |
| | o The total number and the actual hours | | | | | | |
| | | lowing categories of | | | | | |
| | | censed nursing staff directly | | | | | |
| | | esident care per shift: | | | | | |
| | - Registered nurses. | | | | | | |
| | · | actical nurses or licensed | | | | | |
| | | s (as defined under State | | | | | |
| | law). | | | | | | |
| | - Certified nur | | | | | | |
| | o Resident censu | IS. | | | | | |
| | The facility must | post the nurse staffing data | | | | | |
| | | on a daily basis at the | | | | | |
| | * | n shift. Data must be | | | | | |
| | posted as follows | | | | | | |
| | o Clear and read | | | | | | |
| | | place readily accessible to | | | | | |
| | residents and vis | | | | | | |
| | | | | | | | |
| | The facility must, | upon oral or written | | | | | |
| | • | rse staffing data available | | | | | |
| | | eview at a cost not to | | | | | |
| | exceed the comm | nunity standard. | | | | | |
| | | | | | | | |
| | | maintain the posted daily | | | | | |
| | • | ta for a minimum of 18 | | | | | |
| | | quired by State law, | | | | | |
| | whichever is grea | ater. | | | | | |
| | | | F03 | 56 | It is the policy of this facility that | | 03/10/2013 |
| | Based on obse | ervation and interview, | | | staffing will be posted seven d | ays | |
| | | d to ensure the nursing | | | a week.l. No residents were | | |
| | | for licensed and | | | affected. II. All residents could | | |
| | _ | | | | have the potential to be | | |
| | | ff was posted on a daily | | | affected.III.1. Re-education of | | |
| | basis. | | | | week-end Supervisor and the | | |

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| | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|------------------------|--|-----------------------------|--|
| | | 155567 | A. BUILDING B. WING | | 02/22/2013 | |
| | PROVIDER OR SUPPLIE | I R TH AND REHABILITATION CENTE | STREET | ADDRESS, CITY, STATE, ZIP CODE IEDICAL PARK DR WAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| | 9:30 a.m., on 2 staffing hours reception desk 2/13/13. The Administra 9:10 a.m., on 2 CNA # 8 was rethe nurse staff CNA #8 was ir a.m., on 2/20/2 was the sched normally poster hours daily, but | al tour of the facility, at 2/18/13, the nursing were posted at the front x, but were dated ator was interviewed, at 2/20/13 and indicated responsible for posting ring schedule. Interviewed, at 9:12 13, and indicated she uler. She indicated she ed the nursing staffing at did not work I no one was assigned | | scheduler on the procedure for posting staffing, 3-5-13. (see attachments 4+5) 2.MOD will check to ensure, current staffing are posted in a prominent location. 3. Copies of weekend staffing sheets will be kept in a Binder in Don office. In order to validate that staffing was posted on weekly basis by the DON of Designee. IV. Staffing binder to be brought to QMP by the DO or Designee for review by the committee for 6 months. V. Completion March 22, 2013 | gs d a o ed, or | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | JLTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY | |
|--|---|------------------------------|------------|-------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155567 | B. WIN | | | 02/22/ | 2013 |
| | | | b. WIN | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | IEDICAL PARK DR | | |
| | NTV DADIZ LICALTI | H AND REHABILITATION CENTE | D | | WAYNE, IN 46825 | | |
| UNIVERS | DIII FARK HEALII | H AND REHABILITATION CENTE | Г | FORT | WATNE, IN 40625 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0428 | 483.60(c) | | | | | | |
| SS=D | DRUG REGIMEN | I REVIEW, REPORT | | | | | |
| | IRREGULAR, AC | CT ON | | | | | |
| | The drug regimen of each resident must be | | | | | | |
| | | once a month by a | | | | | |
| | licensed pharmac | pist. | | | | | |
| | | | | | | | |
| | The pharmacist n | | | | | | |
| | | e attending physician, and | | | | | |
| | | rsing, and these reports | | | | | |
| | must be acted up | | F0.4 | 20 | | | 02/10/2012 |
| | Based on record review and | | F04 | 28 | It is the policy of this facility to | | 03/10/2013 |
| | | acility failed to ensure | | | GDR on residents who are on | | |
| | a recommenda | ition for a Gradual | | | Psychotropic medications ever Quarter or as needed. I. No | У | |
| | Dose Reductio | n was acted upon by | | | ., | No | |
| | | for 1 resident in a | | | negative outome to resident.II. other residents were | INO | |
| | | esidents reviewed for | | | affected.Residents who have h | her | |
| | - | | | | a quarterly MDS due in the last | | |
| | _ | Medications, Resident | | | Quarter were audited by the S | | |
| | #15. | | | | and Pharmacy consultant to | - | |
| | | | | | ensure compliance. (See | | |
| | Findings includ | le: | | | attachment #9&9a)III.Behavio | r | |
| | | | | | Management will be done by | | |
| | The clinical rec | cord for Resident #15 | | | Pharmacy Consultant, SSD, D | on | |
| | | at 2:00 p.m., on | | | or Designee | | |
| | | | | | monthly.Recommendations wi | | |
| | _ | noses included, but | | | be reviewed at exit conference | | |
| | | d to, senile dementia | | | with Pharmacy Consultant and | | |
| | with delusions, | depression, and | | | Don or Designee.SSD will revi | ew | |
| | anxiety. | | | | recommendation with MD. for | _ | |
| | | | | | approval or denial of the order | | |
| | Current Physic | ian orders. | | | SSD will give the MD orders to Nurse Unit managers for follow | | |
| | _ | igned by the physician | | | up and processing. (See | v | |
| | _ | • • • | | | attachment # 10)IV. Audit Tool | I | |
| | | 2/12, indicated the | | | was implemented for SSD to | 1 | |
| | | eceiving Abilify (an | | | ensure that all MD orders for | | |
| | antipsychotic m | nedication) 15 | | | GDR's aree completed within | | |
| | milligrams, by r | mouth, daily, and | | | 72hours. (See attachment #9 | & | |
| | Sertraline (Zolo | oft), a medication used | | | 9a) This tool will be done on a | | |
| | for depression, | • | | | monthly basis by the Social | | |
| | .5. 456.000.011, | | 1 | | 1 | | I |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTI | PLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|-----------|--|--|------------|--------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | G | 00 | COMPL | ETED |
| | | 155567 | B. WING | | | 02/22/ | 2013 |
| | | | ST | REET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIEF | C | 14 | 100 MI | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENTE | R F0 | ORT V | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID |) | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PRE | FIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TA | .G | DEFICIENCY) | | DATE |
| | The Director of interviewed, at 2/22/13, and in current physici supposed to be physician, but electronically s 12/12/12. Review of an In Psychopharma dated 4/11/12, was taking Abi for delusions a milligrams daily Interdisciplinar the resident coepisodes of ag but was not du medications at A review date of form, indicated and behavior would refer to evaluation of the A review date of form, indicated stable at this tirefer to the physicial supposed in the property of the pro | f Nursing was 10:30 a.m., on idicated these were an orders, and were e signed monthly by the the physician had not signed the orders since Interdisciplinary acological Review form, indicated the resident lify 15 milligrams daily and Zoloft 100 by for depression. The by Team (IDT) indicated bottinued to have itation and delusions, the for reduction of this time. Interdisciplinary acological Review form, indicated the resident lify 15 milligrams daily and Zoloft 100 by for depression. The by Team (IDT) indicated bottinued to have itation and delusions, the for reduction of this time. Interdisciplinary acological Review form, indicated the resident for Interdisciplinary acological Review form, indicated the resident indicated the resident indicated the resident for Interdisciplinary acological Review form, indicated the resident indicat | | | Service Director, to ensure compliance, V. Audit tools will brought to QMP for committee review for 6 months. Completic by March 22, 2013. | | DATE |
| | | rvice Director was 2:10 p.m., on 2/21/13, | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet Page 16 of 29

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567 | | A. BUI | LDING | NSTRUCTION 00 | (X3) DATE COMPL 02/22/ | ETED | |
|--|---|---|--------------|---------------|--|--------|------------|
| NAME OF D | ROVIDER OR SUPPLIER | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | OZIZZI | 2010 |
| | | · H AND REHABILITATION CENTE | R | | EDICAL PARK DR VAYNE, IN 46825 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | T | ID | | | (X5) |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | after the Behavior | - | TAG | DEFICIENCY) | | DATE |
| | | Committee met, with | | | | | |
| | _ | in attendance, a | | | | | |
| | • | port from the Behavior | | | | | |
| | Management C | Committee for a gradual | | | | | |
| | dose reduction | of the medication | | | | | |
| | | to the physician for | | | | | |
| | | ommendations. She | | | | | |
| | | ecommendation for the | | | | | |
| | • | eduction of Abilify was sician, but she could | | | | | |
| | | entation the forms | | | | | |
| | were received | | | | | | |
| | physician. She | | | | | | |
| | | supposed to return the | | | | | |
| | form to the faci | lity with his | | | | | |
| | | ons within 72 hours. | | | | | |
| | | vice Director indicated | | | | | |
| | | ıltation form was | | | | | |
| | | nit managers were | | | | | |
| | | ssure the physician ted upon and written. | | | | | |
| | | vice Director indicated | | | | | |
| | | upposed to receive a | | | | | |
| | | the Consultation form | | | | | |
| | • | igned. She indicated if | | | | | |
| | the form was n | ot returned to the | | | | | |
| | facility within 7 | | | | | | |
| | | ons, the physician | | | | | |
| | | d. She indicated she | | | | | |
| | been done. | locumentation this had | | | | | |
| | been done. | | | | | | |
| | | | | | | | |
| | At 2:50 p.m., o | n 2/21/13, the Director | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|-------------------------------|---------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | л ріп | LDING | 00 | COMPL | ETED |
| | | 155567 | B. WIN | | | 02/22/ | 2013 |
| | | | B. WIIV | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | | | EDICAL PARK DR | | |
| LINIVER9 | SITY DARK HEALT | H AND REHABILITATION CENTE | -D | | VAYNE, IN 46825 | | |
| | | | -11 | | VATIVE, IIV 40023 | , | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LISC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | vices (DNS) provided 2 | | | | | |
| | | eports addressed to | | | | | |
| | the resident's p | ohysician regarding | | | | | |
| | gradual dose reduction of the medications. | | | | | | |
| | | | | | | | |
| | Review of the | first Consultation | | | | | |
| | Report, at 3:00 p.m., on 2/21/13, and | | | | | | |
| | dated 10/4/12, | - | | | | | |
| | - | agement Committee | | | | | |
| | | ommendation to the | | | | | |
| | | e form indicated the | | | | | |
| | | urrently receiving | | | | | |
| | | grams daily and Zoloft | | | | | |
| | | • | | | | | |
| | | The recommendation | | | | | |
| | • | ase consider a gradual | | | | | |
| | | , perhaps decreasing | | | | | |
| | Abilify to 10 mg | - | | | | | |
| | concurrently m | • | | | | | |
| | _ | of target and /or | | | | | |
| | withdrawal syn | nptoms. If therapy is to | | | | | |
| | continue at the | current dose, please | | | | | |
| | provide rationa | lle describing a dose | | | | | |
| | reduction of Zo | oloft as clinically | | | | | |
| | contraindicated | d. " | | | | | |
| | This form was | not signed by the | | | | | |
| | physician, nor | • | | | | | |
| | | ons made by the | | | | | |
| | physician. | | | | | | |
| | الماني الماني الماني | | | | | | |
| | Review of the | second Consultation | | | | | |
| | | 1/3/13, indicated the | | | | | |
| | • | | | | | | |
| | | eceiving Abilify 15 mg. | | | | | |
| | · · | t 100 mg. daily. | | | | | |
| | | ndation indicated, | | | | | |
| | "Please consid | ler a gradual dose | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet Page 18 of 29

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567 | A. BUILDING 00 | COMPLETED 02/22/2013 |
|--|--|-----------------------|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTE | B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825 | 1 |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | |
| reduction, perhaps decreasing Abilify to 10 mg. daily while concurrently monitoring for re-emergence of target and /or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction of Zoloft as clinically contraindicated. " This form was not completed or signed by the physician. The Director of Nursing Services (DNS) was interviewed at 9:38 a.m., on 2/22/13, and indicated the facility did not have a policy for Gradual Dose Reduction(GDR) of Medications, but she provided a "Procedure for GDR" at 9:38 a.m., on 2/22/13, which she indicated she had documented for the procedure the facility followed for GDR. The procedure she provided indicated, "Behavior Management is completed monthly with attendance from the social service director, director of nursing/designee, and pharmacy consultant. Each resident is evaluated per the MDS(minimum data set) calendar to ensure that they are evaluated quarterly. Once the behavior management team has concluded recommendations(sic) from the meeting. Steps are as | TAU DESCRIPTION OF THE PROPERTY OF THE PROPERT | DATE |
| follows:" | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567 | | | ULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE S COMPLE | ETED |
|---------------|--|--------------------------------|--------|---------------------|---|-----------------------|------------|
| | | 155567 | B. WIN | | | 02/22/2 | 2013 |
| NAME OF P | PROVIDER OR SUPPLIER | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENTE | R | | EDICAL PARK DR VAYNE, IN 46825 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | `` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | + | TAG | DLI ICILIACT) | | DATE |
| | | mendations were given | | | | | |
| | to the DNS by consultant. | ше рпаппасу | | | | | |
| | The recommendations were then given to the Social Service Director | | | | | | |
| | | | | | | | |
| | (SSD) for revie | | | | | | |
| | 3. The SSD re | | | | | | |
| | | ons and then rounds | | | | | |
| | | priate physician for | | | | | |
| | evaluation. | | | | | | |
| | | ysician had reviewed | | | | | |
| | I - | ommendations, they | | | | | |
| | were returned | | | | | | |
| | 5. The SSD th | en forwarded | | | | | |
| | recommendation | ons to the Unit | | | | | |
| | Managers for f | ollow up and order | | | | | |
| | implementation | า. | | | | | |
| | 6. The SSD the | en followed up to | | | | | |
| | ensure all reco | mmendations and | | | | | |
| | physician orde | rs were completed | | | | | |
| | within 72 hours | 5. | | | | | |
| | | | | | | | |
| | 3.1-25(j) | | | | | | |
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Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| - | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 02/22/2013 | | |
|--------------------------|--|---|--|--|---|----|----------------------------|
| | NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER (VALID SUMMARY STATEMENT OF DEFICIENCIES | | | | DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0WU111 Facility ID: 000459 If continuation sheet Page 21 of 29

| | | X1) PROVIDER/SUPPLIER/CLIA | $(\Lambda 2)$ IVI | JETIFEE CC | ONSTRUCTION | (X3) DATE | SUKVEI |
|---------------|--|--|-------------------|---|--|--------------------------|------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A DIIII | DDIG | 00 | COMPL | ETED |
| | | 155567 | A. BUII | | | 02/22/ | 2013 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PRO | OVIDER OR SUPPLIEF | 8 | | | | | |
| LINIMEDOIT | TV DADK HEALT | H AND REHABILITATION CENTE | D | | EDICAL PARK DR WAYNE, IN 46825 | | |
| UNIVERSIT | I I FARR HEALT | TI AND REHABILITATION CENTE | Γ. | FORT | WATNE, IN 40825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | | DEFICIENCY) | | DATE |
| F0463 SS=D | 483.70(f) RESIDENT CALL ROOMS/TOILET The nurses' static receive resident of communication is and toilet and bat Based on inter review, the fac resident call lig correctly when This deficiency residents who is light function R 75. Findings include the right of the wall by the sho bathroom in ro When the string lights were pull functioning, the over the door we sound. LPN #1 tested p.m., on 2/18/ call lights did no indicated he we maintenance n | SYSTEM - //BATH on must be equipped to calls through a ystem from resident rooms; thing facilities. view, and record ility failed to ensure 3 thts were functioning checked. or affected 3 of 40 were reviewed for call desidents #22, 29, and le: I lights, 1 on the wall to toilet, and 1 on the ower stalls, in the om 315 were tested. gs attached to the call | F04 | | It is the policy of this facility thall resident call lights function correctly. I. No negative outcor for residents # 22,29,75II. All other residents have the poter to be affected. III. Facilitity wide audit was done to check the clights for proper function. (see attachment # 6). They were found to be working properly. Audit tool will be implemented and done on a monthly basis, and done by Maintenance Director or Designee, thru out the facility, ensure that all call lights are working correctly. (see attachment # 6,6a) They will a be documented on the electronnic TELS system and twill be reviewed by the ED monthly. IV. Audit tools will be brought to the monthly QMP meetings by the Maintenance Director, for committee review ensure ongoing compliance, for months. V. Completetion Date: 3/22/2013 | to to to to to to to fix | 03/10/2013 |

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Event ID: 0WU111

Facility ID: 000459

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| | STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------|---|--|-------|-------------------------------|--|
| | | 155567 | B. WIN | G | | 02/22 | /2013 | |
| | PROVIDER OR SUPPLIE | TH AND REHABILITATION CENTE | ΞR | 1400 M | ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (X5) COMPLETION DATE | |
| | independently bathroom, and bathroom with The Maintena observed in the p.m., on 2/18/ The Maintena interviewed, a and indicated pulled the string hard and brok activated the or activated the o | r and took herself to the d Resident #75 used the assistance of staff. Ince Director was the bathroom at 2:45 the light. The Director was the 10:05 a.m. on 2/19/13, someone probably the call lights too the the switch which | | | | | | |

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Event ID: 0WU111

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If continuation sheet

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| | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MI | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|-----------|--|--------------------------------|---------|------------|---|------------------|-----|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED | |
| | | 155567 | B. WIN | | | 02/22/2013 | _ |
| NAME OF P | PROVIDER OR SUPPLIEI | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENTE | R | | EDICAL PARK DR VAYNE, IN 46825 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | ION |
| TAG | | R LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | DATE | |
| | | f Nursing Services was | | | | | |
| | | 11:08 a.m., on 2/21/13, | | | | | |
| | and indicated the IDT held care plan meetings with residents, they would go to the resident's room, and check the room and call lights for functioning as part of the IDT meeting. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | The IDT Asses | ssment and Progress | | | | | |
| | | viewed for Residents | | | | | |
| | #29 and #75, | at 3:00 p.m., on | | | | | |
| | 2/21/13. Resid | dent #29's most recent | | | | | |
| | assessment w | as dated 12/18/12, and | | | | | |
| | Resident #75's | s assessment was | | | | | |
| | | however, even though | | | | | |
| | | fety review section on | | | | | |
| | • | was no documentation | | | | | |
| | regarding the | call lights. | | | | | |
| | | | | | | | |
| | On 2/10/13 at | 8:40 a.m. the call light | | | | | |
| | | 2's room was checked | | | | | |
| | | nction properly. The | | | | | |
| | | ited he had to pull on | | | | | |
| | | ord for the call light to | | | | | |
| | work properly. | - | | | | | |
| | | | | | | | |
| | On 2/21/13 at | 1:45 p.m., an interview | | | | | |
| | | enance Supervisor | | | | | |
| | indicated the | wall receptor where the | | | | | |
| | call light was plugged into was bent so the call light did not function | | | | | | |
| | | | | | | | |
| | properly when | the call light was | | | | | |
| | turned on by th | ne resident. The | | | | | |
| | Maintenance S | Supervisor indicated the | | | | | |

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Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

| | of Correction identification number: 155567 | (X2) MULTIPLE CC A. BUILDING | 00 | COMPLETED 02/22/2013 |
|-----------|---|---------------------------------|---|----------------------|
| | 100007 | B. WING | ADDRESS CITY STATE ZIR CORE | 02/22/2010 |
| NAME OF F | PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE, ZIP CODE | |
| UNIVERS | SITY PARK HEALTH AND REHABILITATION CENTE | | WAYNE, IN 46825 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | call lights are also checked when the resident has their care plan meeting. | | | |
| | • | | | |
| | The Interdisciplinary Assessment and Progress Notes indicated the resident | | | |
| | had a care plan meeting on 2/12/13. | | | |
| | | | | |
| | | | | |
| | 2.4.40(1)/4\ | | | |
| | 3.1-19(u)(1) 3.1-19(u)(2) | | | |
| | 3.1-19(u)(2) | | | |
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Event ID: 0WU111

Facility ID: 000459

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | TE SURVEY | | |
|--------------------------------|---|--|--------------------------------------|--------|---|---|------------|
| AND PLAN OF CORRECTION IDENTII | | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| 155567 | | B. WING 02/22/2013 | | | | 2013 | |
| | | | D. WIIN | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALTI | H AND REHABILITATION CENTER | ₹ | | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F9999 | 3.1-14 PERSO (t) A physical e required for ear facility within or employment. Trinclude a tuber the Mantoux madministered by documentation department-apinstruction in inskin testing, resurbles a previous can be documented in induration with read, and by watuberculin skin to the employer facility must as (1) At the time within one (1) remployment, and thereafter, employment, and the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (12) months, the skin testing shows the stresult during (13) months, the skin testing shows the skin testing | NEL: xamination shall be ch employee of a ne (1) month prior to he examination shall culin skin test, using ethod (TU PPD), y persons having of training from a proved course of tradermal tuberculin ading, and recording ously positive reaction ented. The result shall millimeters of the date give, date hom administered. The test must be read prior e starting work. The sure the following: of employment, or month prior to nd at least annually ployees and nonpaid | F999 | | It is the policy of this facility that mantoux will be given to all perspective employees before hire. I. No residents or staff we negatively affected. II. All residents could have the potent to be affected. An audit of the past 3 mos of new hires audite by the DSD. (See attachment #7a)III. The Director of Staff Developement will administer mantoux at the time of the M.D. physical. (see attachment #7&7a)The mantoux will be read hours prior to orientation and results documented. The seconstep will be scheduled for two weeks from this completion date and time. IV. The Director of st developement will audit all new hires on a monthly basis to ensure continuity in the mantoprocess. Using the Attached autool (see attachement #8)Th results will be brought to the monthly QMP meetings by the DSDfor reveiw by the committed for 6 mos. V. Completion date 32013 | ere ntial ed, the D.'s 48 aff w ux udit e | 03/10/2013 |

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Event ID: 0WU111

Facility ID: 000459

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|--|------------------------------|------------|------------|--|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | |
| 155567 | | | B. WIN | IG | | 02/22/2013 |
| NAME OF D | DOWNED OF SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1400 M | EDICAL PARK DR | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENT | ER | FORT V | VAYNE, IN 46825 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | | cond test should be | | | | |
| | • | (1) to three (3) weeks | | | | |
| | after the first st | tep. The frequency of | | | | |
| | repeat testing | will depend on the risk | | | | |
| | of infection with | h tuberculosis. | | | | |
| | | | | | | |
| | This state rule | was not met as | | | | |
| | evidenced by: | | | | | |
| | | | | | | |
| | Based on reco | rd review and | | | | |
| | interview, the f | acility failed to ensure | | | | |
| | 4 of 5 employe | • | | | | |
| | received a 2nd step Mantoux skin test | | | | | |
| | | s in a timely manner. | | | | |
| | In addition, one of 5 employee's reviewed did not have their initial Mantoux skin test read (#4) before | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | starting employ | yment. | | | | |
| | Findings include: | | | | | |
| | Review of employee #1's record indicated they received their first step Mantoux skin test on 1/2/13 and was read on 1/5/13 and was 0mm | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | e facility failed to | | | | |
| | | 2nd step Mantoux skin | | | | |
| | , | manner (between 1-3 | | | | |
| | weeks after the results are read for | | | | | |
| | the first step). | | | | | |
| | Review of emp | oloyee #2's record | | | | |
| | · | received their first step | | | | |
| | | est on 1/25/13 and was | | | | |
| | | 3 and was 0mm | | | | |
| | 16au 011 1/28/1 | o anu was Unin | 1 | | | 1 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY | | | | | |
|--|--|--|-----------------------|--|--------------------------------|--------|--------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUI | A. BUILDING COMPLETED | | | | |
| 155567 | | | B. WIN | IG | | 02/22/ | 2013 |
| NAME OF P | PROVIDER OR SUPPLIE | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIVERSITY PARK HEALTH AND REHABILITATION CENTER | | | -D | | EDICAL PARK DR | | |
| UNIVERS | SITY PARK HEALT | H AND REHABILITATION CENT | EK | FORTV | VAYNE, IN 46825 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | | | ATE | COMPLETION DATE |
| TAG | | <u> </u> | | TAG | | | DATE |
| | | e facility failed to 2nd step Mantoux skin | | | | | |
| | | 1-3 weeks after the | | | | | |
| | , | d for the first step). | | | | | |
| | results are rea | a for the first step). | | | | | |
| | Review of emr | ployee #3's record | | | | | |
| | I | received their first step | | | | | |
| | | est on 1/2/13 and was | | | | | |
| | | and was 0mm | | | | | |
| | | | | | | | |
| | induration. The facility failed to administer the 2nd step Mantoux skin | | | | | | |
| | test (between 1-3 weeks after the results are read for the first step). | | | | | | |
| | | | | | | | |
| | Toodito dio rod | a for the mot stop). | | | | | |
| | Review of employee #5's record indicated they received their first step Mantoux skin test on 1/9/13 and was | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | 3 and was 0mm | | | | | |
| | | e facility failed to | | | | | |
| | administer the 2nd step Mantoux skin test (between 1-3 weeks after the results are read for the first step). | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Review of emp | oloyee #4's record | | | | | |
| | · | received their first step | | | | | |
| | | 6/13 but the record did | | | | | |
| | | e test had been read. | | | | | |
| | | | | | | | |
| | An interview w | ith the Director of | | | | | |
| | Nursing (DN) | on 2/21/13 at 2:30 P.M. | | | | | |
| | indicated the 2nd step Mantoux skin tests were not administered in a | | | | | | |
| | | | | | | | |
| | timely manner | for employee's 1,2,3,5. | | | | | |
| | | ted employee #4's | | | | | |
| | | was not read in a | | | | | |

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| | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | | LETED 2/2013 | | |
|--------------------------|----------------------|---|--|--|---------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | L S H AND REHABILITATION CENTE | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | | | | | | | | |
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